CBPC

1. Localisation cérébrale unique ou nombre de métastase ≤ 3 en situation métachrone

Dans les rares cas de métastase unique métachrone inaugurale, le traitement chirurgical est en règle générale réalisé en première intention et permet le diagnostic de cancer à petites cellules *à posteriori*.
Le plus souvent, il s'agit d'une rechute cérébrale seule après CBPC traité, et le diagnostic est fait implicitement du fait de l'antécédent de cancer bronchique à petites cellules ou après biopsie chirurgicale.

- **Radiothérapie en conditions stéréotaxiques :**
  IET : Une radiothérapie cérébrale *in toto* est recommandée dans tous les cas, à la dose de 30 Gy en 10 fractions ou 37,5 Gy en 15 fractions avec éventuellement un *boost* sur le lit d'exérèse chirurgicale, en l'absence d'irradiation cérébrale prophylactique antérieure (IPC).
  RTS : Néanmoins, une radiothérapie stéréotaxique peut éventuellement être discutée au cas par cas, en cas de délai long par rapport à la prise en charge initiale, et en l'absence d'évolution extra-cérébrale (69). En cas d'antécédent d'IPC, une irradiation en mode stéréotaxique est à privilégier.
  En cas d'antécédent d'IPC, une irradiation en mode stéréotaxique est à privilégier.

- **Chimiothérapie :**
  Suite aux résultats de l'étude IMPower 133 (70) et de l'étude CASPIAN (71), le traitement de référence des patients présentant un cancer bronchique à petites cellules métastatique, PS 0 à 2 est aujourd'hui la chimiothérapie par platine-etoposide associée à l'atezolizumab ou le durvalumab ou la chimiothérapie par cisplatine-etoposide associée au durvalumab, 4 cycles. Chez les patients non progressifs il est recommandé une maintenance par immunothérapie seule jusqu'à progression ou toxicité inacceptable. Dans l'étude IMPower 133, 8,5 et 8,9% des patients respectivement avaient déjà des MC traitées et stables à l'inclusion. Il n'a pas été observé de bénéfice à l'ajout de l'atezolizumab chez ces patients mais le nombre de patients est faible (N=35), de même dans l'étude CASPIAN ou 10% des patients des 2 bras présentaient des MC asymptomatiques traitées ou non traitées.
  En cas de rechute cérébrale seule chez un patient ayant déjà reçu une première ligne par sels de platine-étoposide, une chimiothérapie de seconde ligne est à discuter, suivant l'âge, le PS, les comorbidités et le délai entre la fin du traitement de première ligne et la rechute cérébrale. La chimiothérapie privilégiera la reprise de l'association de sel de platine étoposide en cas de rechute cérébrale au-delà de 3 mois après la fin de la première ligne thérapeutique. Elle sera réalisée à distance de la radiothérapie cérébrale. Dans les autres cas (ré-évolution à moins de 3 mois), les associations C.A.V, carboplatine-paclitaxel ou une monothérapie par topotecan seront préconisées (➔ référentiels CBPC).

Recommandations

En cas de métastases cérébrales métachrones d'un CPC :
-En l'absence d'IPC antérieure, une IET est à privilégier.
-En cas d'IPC antérieure, une Irradiation stéréotaxique est à privilégier quand elle est possible.
-Une chimiothérapie doit être réalisée si possible, l'indication et le protocole seront discutés en RCP.

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